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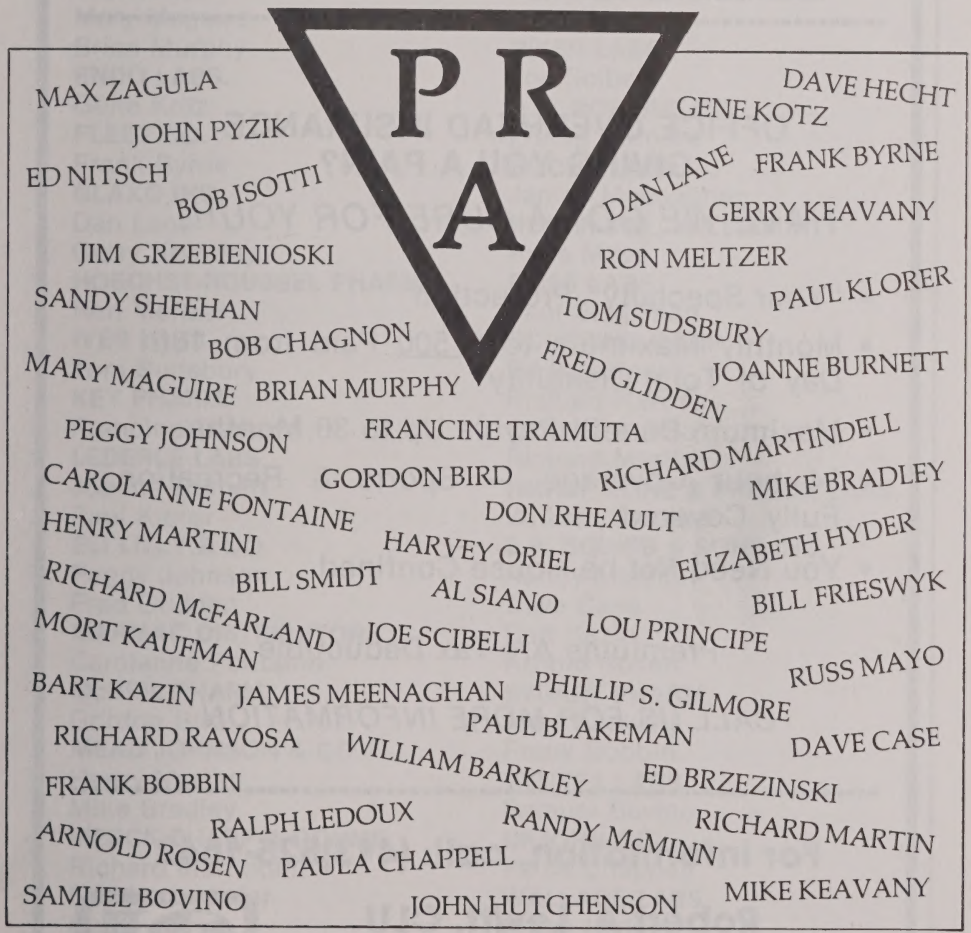

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1982 - 1983 SEASON

Annual Meeting

PLACE:	Storrowton Tavern Stagecoach Barn West Springfield, Massachusetts
DATE:	Tuesday, April 26, 1983
BUSINESS MEETING:	6:00 P.M.
SOCIAL HOUR:	7:00 P.M.
DINNER:	7:30 P.M.

Election of Officers Annual Committee Reports
Treasurer's Report
Presentation of 50 year certificates
Presentation of Certificates to New Members

SPEAKER: Frank J. Jirka, Jr., M.D.
President Elect, American Medical Association

If you must cancel your dinner reservation, call the office before noon on April 26th. If the cancellation is not made you will be BILLED for your dinner.

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MARCH 1983 VOL. XXXXI NO. 3

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The official bulletin
for The Hampden District
of the Massachusetts
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William A.R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.
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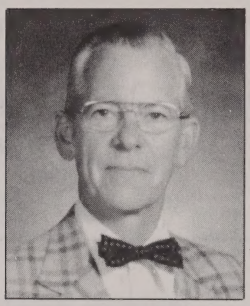

Garry deN. Hough, III, M.D.
President

PRESIDENT'S PAGE

CHANGE

One of the most constant trite remarks is that we live in a changing world. This was the focus of the recent AMA Leadership Conference, as reported by president-elect Terry Ryan in this issue. We were reminded that physicians and their medical societies will have to respond to changes in medicine, economics, and government if we are to provide optimal medical care.

Some changes are slow and subtle, such as the changing attitude and expectations of both physicians and patients. Your medical society is trying to understand these changes by encouraging residents, women, and newly established physicians to present their ideas and take responsibilities in the society. These groups are underrepresented in HDMS and may have a better understanding of changing attitudes than other members. If you fit in one (or more) of these categories, you can help us respond to change by increasing your HDMS participation.

Some changes are recurring, such as the change of officers at the 1983 HDMS Annual Meeting to be held at Storrowton, 6 PM, April 26. We are changing the format this year by meeting jointly with the Hamden District Auxiliary and the John Hunter Club for the 7 PM hospitality and the 7:30 PM dinner. Our speaker will be Dr. Frank Jirka, president-elect of the AMA, who can tell us something of the national medical response to change.

Some changes require hard work, such as providing our elected representatives with information to help them make decisions in health care legislation. Often this means trying to avoid change or reverse previous changes, an unrewarding role familiar to physicians. More and more, the MMS is taking the lead in promoting health bills which are beneficial to physicians and patients. Our legislative committee works hard to do this for us, but they cannot do it alone. *You* can influence legislation, but it requires preparation, thought, and timing. Firing from the hip is as useless as complaining in the coatroom. Contact Terry O'Neill, your legislative chairman.

Some changes require follow-up action to succeed. Last year, the

AMA got the federal government to change its mind on requiring patient package inserts (PPI's) in every prescription bottle in favor of patient medication instructions (PMI's) sheets developed by the AMA. These are now available for 30 drugs or drug classes. Their acceptance by physicians is being monitored by the FDA. We can try these handouts to see if they improve patient understanding and compliance or we can return to mandated PPI's. It's up to you.

Some changes occur so rapidly they cannot be predicted accurately, such as the distribution of Medicaid contract forms by the Mass. DPW. Any information distributed to you by your society, including the reports of the Tax Supported Medical Care Committees in this issue and last month's, are obsolete by the time they reach you. Legal opinions of the proposed contract have been obtained and are sometimes no longer pertinent by the time they are are received. In some ways, the contract is not a change, but an acknowledgement of rules already imposed. There have been promises of reconsideration, multiple postponements, and conflicting rumors. We will try to update you at the April 26 business meeting, but that may not be timely. If the forms come out, be sure to read the contract and *all* the explanations, including its duration, financial disclosure requirements, audit techniques, hiring requirements, and appeal mechanism. Then make your own decision. That is how changes are made. □

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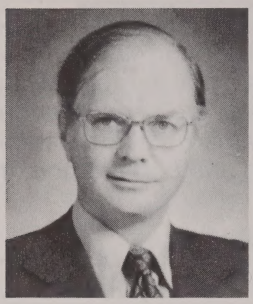

Report of AMA Leadership Conference — 1983

TERRY D. RYAN, M.D.
President Elect HDMS

The AMA Leadership Conference held in Chicago, February 17-19, was attended by approximately one thousand state and county leaders of which about forty came from Mass.; your HDMS was represented by Garry De N Hough, M.D., HMDS Pres., J.J. Siragusa, M.D., HDMS Executive Councilor, Vivian Purdy, R.N., HDMS, Exec. Sec. and your correspondent (T.D.R.) as attendees and by Enzo DiGiacommo, M.D., V.P. at Mercy Hospital, as a speaker. The conference's theme was "AGENDA FOR ACTION". It concentrated on four areas:

1. The Changing Profile of Medicine
2. The Changing Economic Realities
3. The Changing Medical Society

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4. The Changing Governmental Focus

I shall attempt to highlight these long and wordy sessions and then offer a few personal observations.

I. The Changing Profile of Medicine

This initial session discussed such problems as integrating the medical staff into the AMA, coping with competition, and new delivery modes. In this latter session our own Enzo DiGiacomo, M.D., of Mercy Hospital, discussed the inception and organization of a Hospital based Primary Care Group while Robert Taylor, M.D., representing the American Academy of Family Physicians spoke of the need of maintaining independent primary care practitioners.

II. The Changing Economic Realities

It is not business as usual was the emphasis of this section. Lively discussions were stimulated by the presentations of James Sammons, M.D, (AMA Executive Director), J. Alexander McMahon (Pres. of AHA), Jack K. Shelton (Manager of Employee Insurance Ford Motor Company), and Robert J. Ruben, M.D. (Assistant Secretary of HHS). All agreed that major changes in this nation's ability to contain health care costs are necessary. Dr. Sammons warned of the danger of reducing the quality and availability of health care. Mr. Ruben discussed the Reagan Administration's plan presented in the current budget (FY 83).

1. Providing for catastrophic coverage for Medicare beneficiaries while increasing beneficiaries co-payments during the first 60 days of hospitalization;
2. Adoption of prospective payment methodology for Medicare;
3. Limiting the tax free status of employer paid health insurance benefits;
4. Medicare vouchers;
5. Freeze of physicians' Medicare reimbursement;
6. Other changes to reduce Medicare costs.

Mr. McMahon, President of the American Hospital Association

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stated that he favored more cost sharing, e.g. less first dollar coverage by insurance, and extending the prospective pricing concept proposed for Medicare to all hospitalization insurance, tying this in to diagnostic related groups, DRG, which would be expanded and more sophisticated than the N.J. experiment. Mr. Shelton stated that Ford advocated a multi-pronged approach.

1. Greater use of co-payments and deductibles (the UAW strongly opposes this)
2. Mandatory second opinions for surgery
3. Out patient surgery
4. New payment arrangements with physicians, such as through HMO's and PPO's
5. Improved plan administration and better data collection on employee health.

III. The Changing Medical Society

This session was aimed at evaluating the membership of medical societies and comparing the programs of various state societies. The problems discussed reflect

1. The changes in attitudes of younger physicians towards organizations and leadership, e.g. replacement of common good goals by personalized self directed goals
2. The marked increase in the heterogenicity of practice patterns, e.g. private practice physicians, academicians, hospital based physicians, HMO physicians, PPO physicians, etc.

IV. The Changing Governmental Focus

This session featured Senator Orin Hatch, Republican of Utah, and Governor Richard Snelling, Vermont. Senator Hatch praised the new Federalism thrust of the Reagan Administration as seen in switching the control of Medicaid health cost to the states as represented by the Block Grant Program and generally supported President Reagan's health care reform and sent his proposal as was outlined previously by Dr. Ruben. He emphasized the urgency of developing a workable plan to contain health costs. Governor Snelling, however, did not think that the Block Grants were having much immediate effect. He advised physicians to take more political initiative by "talking to their patients" and to become involved in a wider spectrum of political ac-

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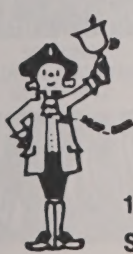
tivity. He cast political doubt on the workability of the Diagnostic Related Grouping Plan.

Comment; Your correspondent was pleasantly surprised by the vigor and strength of your AMA leadership and organization and was struck by the commonality of concerns shared by physicians, medical societies, and hospitals nationwide. From this meeting entitled "Agenda for Action" I came hone with the opinion that "Action" must be concentrated on two areas

1. Understanding and adapting to new economic realities
2. Solidifying medicine's ranks to insure that intraprofessional competition being stimulated by these "realities" is not allowed to erode and splinter our profession.

In considering the "new economic realities" allow me to try to place these realities in an historical prospective. The post WWII era presented an increasing demand for socialized medicine lead primarily by "labor". This was averted by your AMA with the help of business and industry. Instead Medicare was founded to protect the elderly, Medex type programs were founded for the medically indigent while industry cared for its own privately. The combination of these programs have been so successful in making funds available for the growth of the health care industry that growth in availability and technology of health care has far outstripped the nation's growth. Now government sees the Medicare trust fund heading towards bankruptcy and industry perceives that rapidly increasing health care costs are depriving it of the funds it needs for its own future growth. Thus medicine has been funded into an untenable position. Government and industry have both concluded that they must find means of containing hospital cost and are looking at plans like prospective pricing plans with Diagnostic Related Grouping and controlling of physician's fees via increased competition among physicians in private practice, HMO's, PPO's, and hospitals. If this does not halt health care inflation shortly (within a few years) *conservative* government spokesmen and industry spokesmen state that the only alternative is to come back the full circle towards socialized medicine. However, this time some of the players will have changed sides; government and industry will be coming down on the side of labor — a formidable



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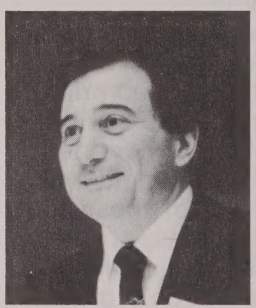
coalition indeed.

Medicine's responsibility is evolving toward a posture sufficiently flexible and cooperative to allow these experiments to succeed while fighting to preserve the quality of care. To accomplish this our organizations must meld all of the competing factions within it in order to insure that all are treated fairly and to insure that our patients' best interests are served. Thus physicians in private practice, HMO's, PPO's and hospitals must compete economically, but remain united professionally in order to make this multifaceted system work to the benefit of the populace they serve or face a certain loss of professional independence while our patients suffer from the inadequacies of bureaucratic medical care. □



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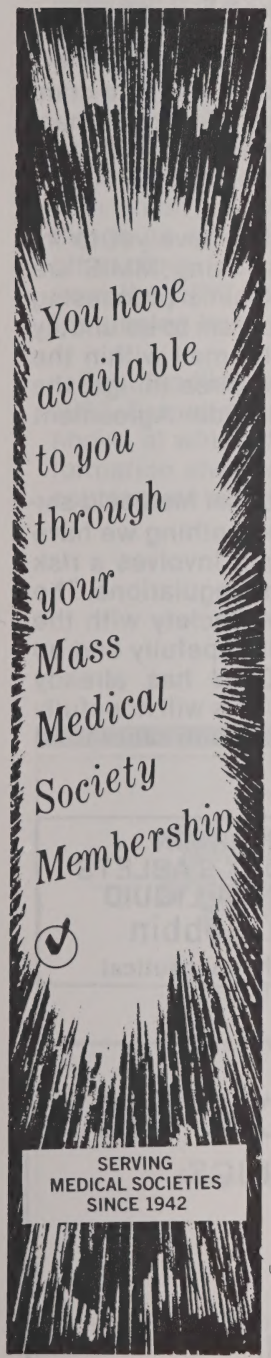

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Massachusetts is one of a dozen or so states that have yet to institute the program. Physicians in states that are using MMIS are satisfied that the system significantly expedites claims processing and reimbursement, and they have not found the program to be unduly cumbersome. All physicians will be receiving in the mail within the next few weeks a thick envelope which will contain three things: the Provider Contract, the billing form itself and the Provider Agreement and Information forms.

CONTRACT - By federal mandate, again any provider of Medicaid services will be required to sign a contract, which is something we have never done before. The signing of any such contract involves a risk because it binds us more closely to existing laws and regulations. The wording of the contract is being negotiated by the Society with the help of our Legal Counsel, Kathleen Curtis. We will hopefully end up with a reasonably innocuous document. The DPW has already begrudgingly agreed to a contract for one year only. This will hopefully avoid some of the Lock-ins that we have experienced with other third party payors.

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THE BILLING FORM is almost indentical to the Blue Shield and Medicaid forms. Like these forms it contains a diagnosis. It has been federally mandated that we use coded diagnoses. We are negotiating with the DPW concerning the coding, the coding system and the cost of the coding books.

THE PROVIDER INFORMATION forms are voluminous but innocuous in content. There is, however, reference in the provider instructions to some already existing Laws that are most desirable and with which we have never been required to comply. They concern such things as reporting of personal or corporate income and loans and other obnoxious provisions. We are in the process of trying to obtain from the DPW written interpretations of the laws that will exempt us from being bound by any of these provisions.

The deadline for implementation is now being delayed to June 1, 1983. Sometime prior to that the DPW will mail the form referred to above, at which the Society will send to all its members an updated information sheet on MMIS. The final decision of participation will, of course, rest with the individual physician. □

J.J. SIRAGUSA, JR., M.D.
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Pharmaceutical Representative Association Members

The first offical meeting of the Pharmaceutical Representative Association (PRA), was held on March 27, 1979. The purpose of forming such an association was to enhance the professional image of the pharmaceutical representative within the community. From its onset, as defined in its bylaws, the PRA has pursued the following:

* improvement of professional relations with physicians, hospitals and pharmacists;
* become involved as an association in both civic and community minded projects;
* initiate social functions between the members of the PRA and other health care associations;
* function by committee, for all to diligently work within the confines of hospital regulations.

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In order to accomplish these objectives, the PRA established a code of ethics, to be adhered to by all its members. This reads as follows:

"All members will conduct themselves in a professional and business-like manner and adhere to the policies and procedures of the PRA, especially using the proper protocol when encountering a fellow member on a physician's office, hospital or pharmacy. A standing committee will also handle complaints voiced by a physician, nurse or receptionist, regarding any member of this association."

Reflecting on our fourth anniversary as an association, finds us with a number of accomplishments to our credit. We have grown in number from an initial attendance of sixteen, to our present membership of fifty-five. We have also extended honorary membership to persons, who although now retired, had been active in our profession for several years...people such as Bill Moran (USV), Ed Volpe (Lederle), Jim Canary (Strasenburg) and the late Doug Wanzer (Upjohn), to name but a few.

In keeping with the primary objectives of the association, the past four years have not been uneventful. In fact, the PRA has been and is involved in numerous diversified areas.

Professionally, we have been successful in working with Gerard Federici, Director of Pharmacy at Baystate Medical Center, in establishing displays at all units of the hospital. This is important, as it often times serves as our only contact with the house staff. In addition, a display program was presented to and accepted by the members of the Amherst Medical Associates, allowing PRA members the opportunity to meet with physicians in a display setting, on a voluntary basis. Mini-fairs have also been established on an annual basis at the Mercy Hospital through the efforts of Ivan Lambert, Director of Pharmacy.

We have worked with Western Mass. Pharmaceutical Association on several occasions in areas of continuing education and fund raising efforts such as Monte Carlo nights. The fruits of these efforts have

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been used to establish annual scholarship assistance for nursing and pharmacy students.

The PRA has also received the support and conversely responded to requests by the Medical Assistants Association, in areas of our mutual concern.

Part of our community involvement includes an organizational network of donations including **Toys for Tots** and the **Springfield Rescue Mission**.

The social aspects of our association have also been plentiful and include our annual installation banquet, Christmas party for members and special Christmas party for children of members.

We have initiated a number of pizza parties, as well as softball, football and hockey games with the residents at Baystate. Weather permitting, we have held sleigh rides in the winter and family picnics in the summer.

Perhaps our most successful social event of the year is our annual golf outing, for physicians, pharmacists and PRA members. This is followed by an awards dinner and truly has become a very special event, enjoyed immensely by all attending.

To encapsulate then, the PRA is a group of professional people whose intent is to work individually and collectively in a cohesive and supportive manner to improve professional liaison between its members and members of the other health care teams. For this reason, we constantly seek creative suggestions from the members of the medical profession and hope that you recognize and appreciate our intent and purpose. Should you have any suggestions or need additional information regarding the PRA, please feel free to contact any of our present officers who are: Richard McFarland (Ortho Pharmaceutical), President; Mary McGuire (Ciba Pharmaceutical), Vice President; Rick Martin (Searle Pharmaceutical), Secretary; and Dan Lane (Glaxo), Treasurer.

We are very greatful for the opportunity extended to us in this printing, to introduce you to the PRA in its official capacity.

PEGGY JOHNSON, RPh, Pharm. M.
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Return to Work — Thursday or Monday?

Our President, Garry Hough, has written in this journal and spoken at recent Hampden District Medical Society meetIngs about the efforts of the Society and the Springfield Chamber of Commerce to attack the problems related to the escalation of costs of medical care in our area. One of the activities emerging from the Greater Springfield Healthcare Coalition, as it is called, is to outline, clarify and hopefully treat difficulties that exist concerning Workers' Compensation.

Representatives from four of our area's larger industries have met with Medical Society members and we have found that Worker's Compensation difficulties are several and similar from their perspective.

They all feel, first of all, that communication between the treating physician and "company" staffs needs to be enhanced in all areas.

1. Return to work should be determined very carefully by the attending physician because costs to a company for a Workers' Comp lost day are approaching $2300! Far more workers return to work on Mondays than any other day of the week. Is this valid, they ask?

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2. Attending MD's should learn about "light duty" return to work at the employee's work place. Perhaps workers could then return sooner, and just as safely.

3. Communication should be improved between attending doctor and the company MD, discussing cases and ultimate disposition, also being aware of in-plant medical facilities for follow-up and treatment.

We are now in the planning phase of trying to improve communications. It is clear that physicians who treate Workers' Comp cases ought to be better informed as to job description, lighter work opportunities and medical follow-up at work, just as business people need to know physicians' problems with reimbursement and lack of information or communication from the workplace.

In order to gain perspective from the treating physician's standpoint, we would invite you to let Drs. Hough, Stoddard or myself know of your views and opinions. In future issues, we will tell of further plans to improve communications. □

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Continuing Medical Education Program

SPEAKER:	GEORGE M. ELIOPOULOS, M.D.
SUBJECT:	"AMINOGLYCOSIDES: USE AND MISUSE"
DATE:	APRIL 11, 1983
WHERE:	PROVIDENCE HOSPITAL
TIME:	7:30 P.M.
CME CREDIT:	2 hours Category 1, Springfield Academy of Medicine

Dr. Eliopoulos is instructor in medicine at Harvard Medical school and assistant to the chairman of the department of medicine at the New England Deaconess Hospital.

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Remarks on Chapter 372

The topic for this evening is Chapter 372 Acts of 1982. This act, as you know deals with reimbursement or hospital payment. It is a new and hopefully an effective way of dealing with the ever rising cost of health care in this commonwealth. A little background.

As most of you know, Blue Cross has long enjoyed a discount on their hospital payments for the subscribers. This, in the eyes of the private insurers seems to be unfair competition, especially in so far as Blue Cross is a tax emempt organization. Furthermore, neither Medicaid nor Medicare pay their full share of patient charges. The end result of this was the so called cost-shifting which allowed hospitals to shift their costs (including the discounts) to the commerical insurers and to the self pay patient. Supported by the Life Insurance Association of Massachusetts and the Health Assurance Association of America, Senator Foley early in 1982 filed a Bill S 495. The M.M.S. became one of the first supporters of this bill — whether because of ingrained opposition to cost shifting or because of our antipathy for anything blue I am not sure. This bill was opposed by MHA and Blue Cross which incidentally supplies 30% of the operating revenues of the hospitals. However, there now entered a new player — the business round table. The business round table is made up of representatives of 55 of the major businesses in Massachusetts. "They pay the bill." They were very familiar with the fact that, whatever the reason, health care costs in Massachusetts are 40% higher than the rest of the nation. The business round table says that the fringe benefits as part of their wage package are somewhere in the vicinity of 20-25% of the total — an especially high figure in relation to other parts of the country Parenthetically, how often have we physicians told the blues, trustees, and anyone who would listen, that first dollar coverage is too much, that many procedures and ancillary services could be delivered as well in a physician's office as in the hospital?

At this point, the Business Round Table convinced all interested parties including the state (Department of Human Services) to sit down together to work out an appropriate bill. At first MMS was left

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out and even rebuffed by the Business Round Table until we held a talk with their representatives and pointed out who had been the earliest supporter of Senator Foley's bill. From that point on, the MMS became part of the coalition established to concern itself with health care costs (Business Round Table, MHA, MMS, Life Insurance Association of Mass., Blue Cross, and the Department of Human Services). It is apparent that this coalition will continue well into the future and will concern itself with many other areas of health care. Early on Mr. Kinzer of MHA publically declared that the bill would not work without the cooperation and input of physicians. (Fortunately, in my opinion, even before that, one of the objectives of my own administration was to improved the relationship between the MHA and MMS and this was already being implemented.) Following concensus, the bill eventually passed into law, after federal waivers on Medicaid and Medicare had been obtained so that one formula could affect all payors. Your MMS agents lobbied in Washington and via telephone with the aid of AMA and I personally think that some of Bill Munier's (your executive vice-president) contacts from his previous work in Washington paid off. When Governor King signed the bill, I personally pledged to Governor King and Senator Foley and all assembled that the MMS would do its best to help in attaining the objectives of Chapter 372.

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This is a very complicated document, one that needs study by someone much smarter than I.

What does it do?

1. No more cost based reimbursement.
2. 1981 is base year — hospital will be reimbursed by what they received in 1981 adjusted to inflation in subsequent years — no matter what the costs are. However, each year they will get a little less - about 1% of the so called productivity or efficiency factor.
3. If the hospital exceeds the limit — it loses; if it comes under, it keeps most of the excess.
4. There are regional limits called MACs (maximal allowable costs), — if one hospital goes out of business in an area, the remaining hospitals can canibalize the other hospital's MAC.
5. Capital expenditures approved through the DON are passed through the MAC, those too small for a DON of disapproved come out of the MAC.

One can see that the hospital now has incentives to restrain inpatient admissions, reduce length of stay, provide outpatient services or other alternatives to inpatient admissions and reduce the supply of ancillary services. New, highly specialized low volume services will be discouraged. This then wil encourage referral of patients to hospitals where the services are already offered, as in tertiary hospitals. So called unbundling of services will be encouraged. If volume increases, charges will be adjusted downwards and vice versa.

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Where does the physician come in?

The MMS has to be deeply involved because it has always been a patient advocate and I do not at present see any of these coalition members playing the role as it seems to me that everyone else with the sole exception of the MHA is more interested in the economics that the quality of health care. Who is it who says optometric care is higher or equal in quality to opthalmalogic care; who is it who says the nurse in the extended role can take the place of the physician; who is it who says send the patient 20 to 40 miles for a CAT scan?

I point out to you that MMS is the oldest medical society in the U.S. — older than the Harvard Medical School, older than most of the hospitals. Indeed it was incorporated by the Commonwealth under Chapter 15 of the Acts of 1781. I should like to read to you Section Two under those acts of incorporation.

"The purpose of the MMS shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed of liberal principles for the health and benefit and welfare of the citizens of the Commonwealth." An all encompassing statement isn't it?

Let me recall for you an even older statement given in 200 A.D. "I will follow that system or regimen which according to by ability and judgement I consider to be to the benefit of my patient and abstain from whatever is deleterious and not meritorious." (Hippocrates)

We must, therefore, continue our role as patient advocates. We must understand, however, from whence the other members of the coalition are coming. It is my considered opinion that MHA and MMS must work together.

Well, where does the physician come in?

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Incentives for physicians are still the same and now are potentially at odds with those of the hospital.

If physicians admit many cases which could be cared for outside the hospital and order tests in large quantities it could financially jeopardize the hospital.

What affect do professional liability costs have?

What input have physicians had on what appears to be the initial reaction of hospital administrators — namely to freeze jobs, layoff nursing personnel, economize on materials, but who fail to curtail administration? In the long run this approach won't work, it will have a serious detrimental effect next year and the year after.

Only physicians can differentiate between the necessary and unnecessary care and eliminate the latter. Ultimately physicians will be held accountable for such decisions and the financial liability of the hospital may depend on the physicians.

What's ahead?

The coalition (somewhat due to our presence and pressure) is waking up to the fact that:

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1. Physician reimbursement incentives have not changed while those for hospitals have.
2. Physician behavior may spell financial success or failure of a hospital.
3. Physician behavior is in part affected by physician reimbursement policies.
4. What effect does the increase in number of physicians have on the old health care cost question.
5. What is competition? Every physician (fee for service, HMO, hospital based) must decide for himself.

I should like to now briefly tell you that a year ago the executive board and officers of the MMS met for a retreat at the Endicott House. One of the problems which the MMS identified at this meetings was "The Impact of Outside Forces on the MMS — What are Those Forces?" A subcommittee of the executive board, called Endicott Committee has already identified Chapter 372 as one of the outside forces. There will be recommendations and advice coming within the next six weeks.

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"You & Your Medicine" a program sponsored by Hampden County Extension Service, West Springfield April 19, 1983 at 7:30 P.M. Call 736-7204.

In the meantime what must be done?

1. Convince coalition that patient education is a must.
2. Work with the hospitals:
   A. To this end the MMS in conjunction with MHA will provide a video tape on the subject.
   B. The MMS had a meeting for the chief's of staff on all acute care hospitals at which MMS, MHA, Business Round Table, the new chairman of hospitals staff's steering committee of the AMA, and a leader in the IPA movement will share in the education.
   C. Board membership — both the large and small hospitals should be targeted for approximately 1 20% membership by physicians.
3. Strong liason with MHA.
4. Legislative — tort reform (if this is not done the increased cost for practice liability will be passed through to the patient), physician incentives (pay the same in the office or hospital, or pay neither the office of the hospital.
5. Relief from the lock in, lock out system.
6. Maintain a strong representation in the "coalition" and attempt to set up coalitions in all areas.

Now for one last announcement — the Mass. Medical Society has obtained the consultatiave services of Paul Elwood, who is president of Interstudy (Minneapolis). As you may know he was probably the originator of the term HMO. He will work with your officers and other appropriate persons on what he sees as the effect of 372 in Massachusetts on physicians and how we as physicians should be further involved.

These are difficult issues. Can we in the MMS dodge our responsibility and accountability to the patients, to the hospitals, to business — the answer is a resounding no! □

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Executive Committee

The Executive Committee met on Monday, February 14, 1983 in the Conference Room of the HDMS.

Present were Drs.: Hough, Walthall, Remsberg, Guardione, Ryan, Pacosa, Bagamary, Mrs. Rich and Mrs. Purdy.

The meeting was called to order by Dr. Hough at 7:40 P.M.

The minutes were approved as amended.

Dr. Hough discussed the minutes of the Committee on the Education and the Library. Charges for "non-member" searches were discussed. Dentists have been invited to join. The survey team will be attending on March 1st for recertification. A membership from Medical West is being sought equal to the hospital membership.

OLD BUSINESS

Dr. Hough discussed the Nuclear Warfare program as described by Dr. Barnshaw. No further information has been given as to date, etc. Dr. Hough will talk with Dr. Barnshaw about this program.

Dr. Hough gave a report on the Leadership meeting held on a state level recently. He will find out about holding such a meeting in the future for officers and other interested members.

NEW BUSINESS

The resolution presented by Dr. Chorowski was discussed. There were two resolutions from the Public Health Committee written by him. This was concerned with TAPPA, Teenage Pregnancy and Prevention Alliance. Resolution #1 was adopted by the Executive Committee and will be printed in the March issue of the Hampden Hippocrat and presented to the membership in the next District meeting. Resolution #2 was tabled until the next meeting.

Dr. Hough discussed the possibility of a non dues paying income source for the HDMS. Several ideas were given such as car leasing, computer services, billing, telephone answering. It was decided that Dr. Hough, Dr. Ryan and Mrs. Purdy will plan to meet with Jim Hickox at the Leadership Conference in Chicago.

The American College of Nuclear Physicians sent information about lectures on radiation from nuclear medicine procedures and low level waste procedures. This will be referred to the Committee on Education & the Library.

Dr. Hough gave an update report on the Business/Medicine Coalition. The sub-committees have been formed and some have had meetings. Other district Presidents have indicated interest in the Coalition.

The League of Women Voters have contacted Dr. Hough for a speaker for a public forum on "How the Local Health Care System Meets the Needs of the Elderly." Dr. Hough will speak at this meeting.

Dr. Hough suggested that at the Annual Meeting in April that an older member cover a group of young physicians (those in practice less than five years) by inviting them to the dinner meeting. He will contact the John Hunter Club and invite them to the meeting.

CORRESPONDENCE

The AMA sent a letter asking for nominees for awards that would be presented at the Annual Meeting in June.

A thank you letter was read from Mrs. Sachsse for Dr. Wallwork attending the last District Meeting.

Dr. Wittenberg has been appointed as liaison member to the Springfield Science Hall of Health.

The meeting was adjourned at 9:00 P.M. □

WILLIAM W. WALTHALL, M.D.
Secretary

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The Visiting Nurse Association of Springfield (VNA) has been providing home based care for terminally ill individuals since the Agency's inception in 1914. Recent changes in the needs and care of the terminally ill, however, have allowed us to expand the scope and depth of our services to include those associated with Hospice Care.

The VNA Hospice Home Care Program is a holistic, family-centered approach to the care of the patient with a terminal illness. The approach with its focus on physical, emotional, spiritual and economic considerations, centers on improving the quality of life during its final stages as well as through the bereavement period.

The objectives of the VNA Hospice Home Care Program are:

1. To enable the patient/family unit to choose home when it is an appropriate place to receive care.
2. To help the patient/family to focus on living by assisting with:
   a. Monitoring and managing pain and symptoms
   b. Coping with problems of daily living
   c. Preparing for impending death
   d. Providing Voluntary Care Givers when appropriate
   e. Supporting the patient/family unit in the transition between home and hospital
   f. Minimizing the effects of the bereavement period.
3. To counsel the patient/family unit on the availability of community resources.
4. To assist the patient/family unit in choosing alternate settings for care consistent with its needs
5. To educate the community regarding the VNA Hospice Home Care program.

Eligibility for Hospice Home Care is made through an assessment by an interdisciplinary team headed by Dr. Charles White, Oncologist at Baystate Medical Center.

Admission criteria include:

1. The patient must have a diagnosis of a terminal illness (limited life-span).

2. The patient must have an estimated life expectancy of six (6) months or less.
3. The patient's stage of illness has reached a point where cure is no longer a realistic goal and aggressive treatment for the terminal illness has ceased and palliative care has begun.
4. There is a commitment by the primary attending physician for the patient to participate in the VNA Hospice Home Care program (e.g., approves entry, endorse the hospice concept, and participates accordingly).
5. A written, informed consent from the patient or the legal guardian of the patient or the significant other in the household must be obtained for VNA Hospice Home Care services.
6. The patient must reside in the geographical areas covered by the Visiting Nurse Association of Springfield, Inc.
7. It is required that a primary care giver assume responsibility for the patient on a twenty-four hour-a-day basis (e.g., a spouse, relative, or friend). Said person must be capable of participating in the patient's care between professional visits. It is preferred, but not required, that this primary care giver be in residence with the patient.

Services available through the VNA Hospice Home Care include Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Services, Homemaker/Home Health Aide, Pastoral Care Giver and Voluntary Care Givers.

Referrals for Hospice Home Care are welcomed and can be made by contacting the Visiting Nurse Association of Springfield at 781-5070. The Visiting Nurse Association of Springfield services:

> Agawam, East Longmeadow, Hampden, Longmeadow, Ludlow, Springfield, Southwick, Westfield, West Springfield and Wilbraham.

Hospice Care is also available through the Holyoke VNA at 534-5691 and the Chicopee VNA at 594-4702. □

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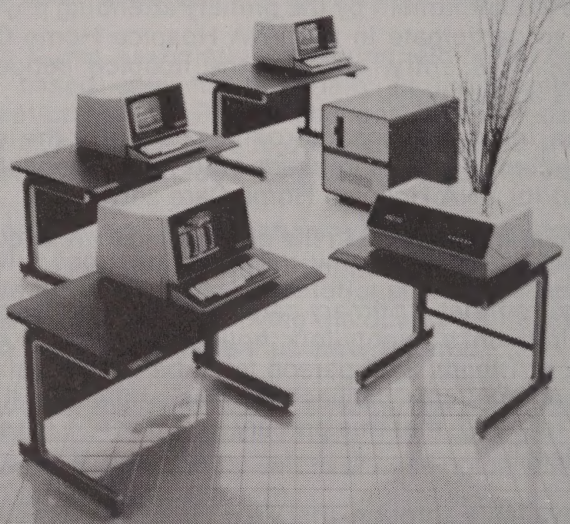

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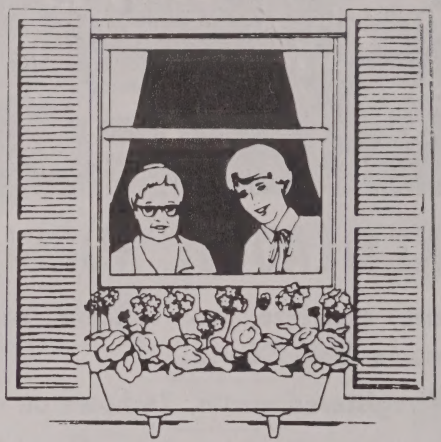

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